AHCCCS THIRD PARTY CHANGE FORM

To: AHCCCS ADMINISTRATION
MFIS, Mail Drop 3600
801 East Jefferson
Phoenix, AZ 85034

To help us update recipient information insurance data, please complete this form, sign, date, and return it.

INSTRUCTIONS FOR COMPLETION: Please print or type. Fill in as much information as possible in the spaces below. An asterisk (*) indicates that the field is required in order to update AHCCCS files. See reverse side for detailed instructions.

COVERAGE BEING REPORTED:
New Medical Insurance   ☐ Information is being **added** (Enter item #s_____)
Medical Insurance Terminated   ☐ Information is being **corrected** (Enter item #s_____)

INSURANCE INFORMATION

1. *Insurance Company Name or HMO Name:_____
2. *Insurance Company Address:_____
3.   Insurance Company Contact:_____ 4. Phone #:_____
5. *Policy ID #:_____ 6. Group #:_____
7. *Begin Date:_____ 8. *End Date:_____
9.   Policy Type (check one): Group ☐   Individual ☐   Hospital ☐   Medicare ☐   Other ☐
10.*Policyholder's Name:_____
11. Policyholder's Phone #: (_____) _____ 12. *Policyholder's SSN:_____
13. Policyholder's Employer:_____
14. Employer's Address:_____

RECIPIENT INFORMATION
Please use another form if more space is needed.

15. *Name	16. *AHCCCS ID	17. *SSN	18. *DOB	19. Relationship of Policyholder to recipient

20.*Signature of person completing form:_____
21.*Health plan/program contractor/provider:_____
22.*Telephone #:_____ 23. *Date:_____

AHCCCS THIRD PARTY COVERAGE FORM

INSTRUCTIONS

A MEDICAL INSURANCE FORM SHOULD BE COMPLETED AND RETURNED TO AHCCCS WHENEVER MEDICAL INSURANCE OTHER THAN THE INSURANCE LISTED ON THE ROSTER IS AVAILABLE, OR INSURANCE AHCCCS HAS REPORTED TO THE HEALTH PLAN OR PROGRAM CONTRACTOR HAS TERMINATED, OR INFORMATION CONCERNING THE INSURANCE IS INCORRECT.

CHECK THE BOX INDICATING THE REASON THE FORM IS BEING SUBMITTED TO AHCCCS.

1. Enter the name of the insurance company or Medicare HMO.

2. Enter the insurance company's street address, city, state and zip code.

3. Enter the insurance company's contact person's first and last name, if applicable.

4. Enter the insurance company's 10-digit phone number (including area code).

5. Enter the insured member's policy number.

6. Enter the insured member's group number, if applicable.

7. Enter the policy begin date (month, date and year).

8. Enter the policy end date (month, date and year), if applicable.

9. Check the box indicating the appropriate policy type.

10. Enter the policyholder's first name, middle initial and last name.

11. Enter the policyholder's 10-digit phone number, including area code.

12. Enter the policyholder's 9-digit Social Security Number.

13. Enter the policyholder's employer's name.

14. Enter the policyholder's employer's street address, city, state and zip code.

15. Enter the AHCCCS recipient's first name, middle initial and last name for those covered under the insurance policy.

16. Enter the AHCCCS recipient's 9-digit AHCCCS Identification Number. If not available, the recipient's Social Security Number must be inserted.

17. Enter the AHCCCS recipient's 9-digit Social Security Number.

18. Enter the AHCCCS recipient's Date of Birth (month, day and year).

19. Enter the relationship of policyholder to AHCCCS recipient; i.e., child, absent parent, guarantor, legal guardian, parent, self or other.

20. Enter signature of person completing form.

21. Enter the health plan/program contractor or provider name associated with the person completing the form.

22. Enter the area code and 7-digit phone number where the person completing the form can be reached.

23. Enter the date that the form was completed.